# APPENDIX 4a
# SAMPLE HCFA 1500 CLAIM FORM
# COMPREHENSIVE SCREEN WITH IMMUNIZATION, HEMOGLOBIN, AND LAB HANDLING FEE FOR LEAD SCREENING
# CLAIM SORT INDICATOR "H"
# RECEIVED BY THE FISCAL AGENT THROUGH 6/30/95
# ANY HEALTH CHECK PROVIDER

## HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

| | | | |
|---|---|---|---|
| 1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER | | | 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) |
| [ ] (Medicare #) [H] (Medicaid #) [ ] (Sponsor's SSN) [ ] (VA File #) [ ] (SSN or ID) [ ] (SSN) [ ] (ID) | | | 1234567890 |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | 3. PATIENT'S BIRTH DATE MM DD YY / SEX | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) |
| Recipient, Im A | MM DD YY M [X] F [ ] | | |
| 5. PATIENT'S ADDRESS (No., Street) | 6. PATIENT RELATIONSHIP TO INSURED | | 7. INSURED'S ADDRESS (No., Street) |
| 609 Willow St. | Self [ ] Spouse [ ] Child [ ] Other [ ] | | |
| CITY / STATE | 8. PATIENT STATUS | | CITY / STATE |
| Anytown / WI | Single [ ] Married [ ] Other [ ] | | |
| ZIP CODE / TELEPHONE (Include Area Code) | Employed [ ] Full-Time Student [ ] Part-Time Student [ ] | | ZIP CODE / TELEPHONE (INCLUDE AREA CODE) |
| 55555 / ( XXX) XXX-XXXX | | | ( ) |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | 10. IS PATIENT'S CONDITION RELATED TO: | | 11. INSURED'S POLICY GROUP OR FECA NUMBER |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [ ] NO | | a. INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ] |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ] | b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State) | | b. EMPLOYER'S NAME OR SCHOOL NAME |
| c. EMPLOYER'S NAME OR SCHOOL NAME | c. OTHER ACCIDENT? [ ] YES [ ] NO | | c. INSURANCE PLAN NAME OR PROGRAM NAME |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | 10d. RESERVED FOR LOCAL USE | | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO If yes, return to and complete item 9 a-d. |
| READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____ | | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ |
| 14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | 17a. I.D. NUMBER OF REFERRING PHYSICIAN | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY |
| 19. RESERVED FOR LOCAL USE | | | 20. OUTSIDE LAB? [X] YES [ ] NO $ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V70.0 2. 3. 4. | | | 22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER |

PHYSICIAN OR SUPPLIER INFORMATION

| 24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 04 01 95 | 3 | 1 | W7000 | 08 | 1 | XX XX | 1 | | | | |
| 2 04 01 95 | 3 | 1 | 90707 | | 1 | XX XX | 1 | | | | |
| 3 04 01 95 | 3 | 1 | 90720 | | 1 | XX XX | 1 | | | | |
| 4 04 01 95 | 3 | 5 | 83020 | | 1 | XX XX | 1 | | | | |
| 5 04 01 95 | 3 | 5 | 99000 | | 1 | XX XX | 1 | | | | |
| 6 | | | | | | | | | | | |

| | | | |
|---|---|---|---|
| 25. FEDERAL TAX I.D. NUMBER SSN EIN [ ] [ ] | 26. PATIENT'S ACCOUNT NO. 1234JD | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO | 28. TOTAL CHARGE $ XXX XX / 29. AMOUNT PAID $ / 30. BALANCE DUE $ XXX XX |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Authorized SIGNED MM/DD/YY DATE | 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) | | 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I. M. Billing 1 W. Williams Anytown, WI PIN# GRP# 87654321 |

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500